SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Conseco Insurance Company

Product Name: CIC-7025 & CIC-8014A1	SERFF Tr Num: CNSC-125847795	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40609
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Stacey Farmer, Janet Jones	Disposition Date: 10/24/2008
	Date Submitted: 10/20/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/24/2008	
State Status Changed: 10/24/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

On7/10/2008 under SERFF File #CNSC-125634477, we received approval of Policy Form CIC-3018-AR and Application CIC-8014A. Subsequent to receiving this approval, we determined that we wanted to make one change to the Minimum Annual Premium Guarantee provision in the policy and revised the medical question on the application. These changes are more beneficial to the insured and will be explained in detail below.

ENDORSEMENT CIC-7025 – Changing the Minimum Annual Premium Guarantee

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

We are filing for approval Endorsement CIC-7025, which is a new form and will not replace any forms on file with your department. This endorsement will increase the minimum annual premium guarantee period from the first five (5) Policy Years to the first ten (10) Policy Years.

The minimum annual premium guarantee is addressed in the Minimum Annual Premium Guarantee provision and in the Grace Period provision of the policy. In these two provision, the only change made is changing the minimum annual premium guarantee period from 5 Policy Years to 10 Policy Years. In all other respects the policy shall remain the same as previously approved by your department.

We wish to make this change across the board for new issues and for in force policies, if any. Once the endorsement is approved and placed into production, we will notify the owners of in-force policies of this change to the minimum annual premium guarantee period and provide a copy of the endorsement for their records. To date, there are no in-force policies in your state.

LIFE APPLICATION SUPPLEMENT - CIC-8014A1

We are filing for approval Application CIC-8014A1, which is a new form and will replace Application CIC-8014A. Application CIC-8014A1 is identical to Application CIC-8014A, except the medical questions in Section 9 have been revised. Instead of asking for medical history for the past 10 years in questions 5 & 6, we are now asking only for medical history for the past 5 years. For Medical Questions 2, 3, 5 and 7, there are only minor wording changes to these questions. For your convenience, a comparison chart of the medical questions between the two applications is attached.

Form CIC-8014A1 is a life application supplement that will be used with Policy Form CIC-3018-AR and other policies that are filed and may be filed at a later date. This supplement will be completed when:

· The Employee is applying for a life insurance policy for his or her child/grandchild;
· Evidence of Insurability is required on the employee and/or employee's spouse;
· The Owner wishes to make a policy change to an in-force policy; or
· The Owner wishes to reinstate the policy.

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

The riders in Section 3 of the application are being filed as variable. By making this area variable, in the future we will be able to delete any rider not being offered any longer or to add any new rider (once approved by the insurance department) to the application. Also, bracketed on the application are the administrative office address and toll free telephone number.

Please note that in the future we may offer our clients the opportunity to complete this application electronically and at that time will be accepting their signature in an electronic format.

This filing does not contain any controversial or unusual items from normal company or industry standards. To the best of our knowledge, attached are any necessary fees and certifications as required by your state.

We reserve the right to make any typographical corrections, or make minor revisions to the appearance of the form due to printing constraints.

Thank you for your time and consideration on this filing. If you have any further questions regarding this filing, please feel free to contact me.

Company and Contact

Filing Contact Information

Stacey Farmer, Compliance Analyst
11825 N Pennsylvania St
Carmel, IN 46032

stacey_farmer@conseco.com
(800) 888-4918 [Phone]
(317) 817-2333[FAX]

Filing Company Information

Conseco Insurance Company
11815 N Pennsylvania St
Carmel, IN 46032
(800) 888-4918 ext. [Phone]

CoCode: 60682
Group Code: 233
Group Name:
FEIN Number: 45-0103436

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Conseco Insurance Company	$50.00	10/20/2008	23332756

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/24/2008	10/24/2008

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/24/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Application comparison chart		Yes
Form	Endorsement		Yes
Form	Application		Yes

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: CIC-7025

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CIC-7025	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Endorsement	Initial		50	CIC-7025.pdf
	CIC-8014A1	Application/Enrollment Form	Application	Initial		52	CIC-8014A1.pdf

CONSECO INSURANCE COMPANY

Chicago, Illinois
Administrative Office: [11825 N. Pennsylvania Street
Carmel, Indiana 46032-4555]

ENDORSEMENT

This endorsement will replace the provisions found in your policy entitled "Minimum Annual Premium Guarantee" and the "Grace Period." This endorsement will become part of your contract and should be attached thereto.

The following provisions hereby amends and supercedes the same provisions in your contract:

MINIMUM ANNUAL PREMIUM GUARANTEE – This policy will not lapse during the first ten Policy Years, if on each Monthly Anniversary date during this period (i) is greater than (ii), where (i) is the sum of all premiums paid to date minus any Indebtedness and minus any partial withdrawals; and (ii) is one twelfth (1/12) of the minimum annual premium shown on the Policy Data Page, multiplied by the number of months elapsed since the Policy Effective Date of this policy, including the month following the Monthly Anniversary date.

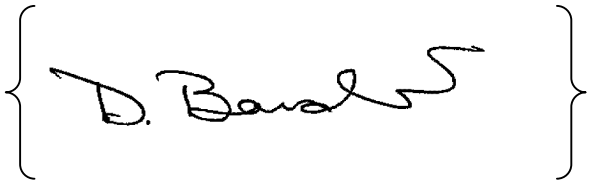
GRACE PERIOD – The grace period begins on the Monthly Anniversary when the Cash Surrender Value is less than the next monthly deduction. You have 61 days from the start of the grace period to pay the premium. We will mail You and any assignee notice of the length of the grace period and the amount of premium due. The amount of premium due is the amount, which is required to keep the policy in force during the grace period plus one additional month's charges. We will send a written notice 31 days before the end of the grace period to Your last known address and the addresses of any assignee of record.

If the Primary Insured dies during the grace period, any past due monthly deductions will be deducted from the Death Proceeds. The policy will remain in force during the grace period, unless surrendered.

See the Minimum Annual Premium Guarantee provision for the method of avoiding lapsing the policy during the first ten Policy Years.

In all other respects the contract shall remain the same

Signed for the Company by:



President

*NBAP*CIC*WS*

LIFE APPLICATION SUPPLEMENT

Conseco Insurance Company

Administrative Office: [11825 N. Pennsylvania Street, Carmel, IN 46032]
Toll Free Telephone Number: [1-800-458-9156]

CONSECO®

☐ **Child/Grandchild Coverage**
☐ **Employee/Spouse – Evidence of Insurability**
☐ **Policy Change to Existing Coverage – Policy #** _____
☐ **Reinstatement – Policy #** _____

SECTION 1 – Employee (Applicant/Owner) INFORMATION – Always Complete		
First Name:	MI:	Last Name: (indicate if hyphenated name)
Date of Birth:		Social Security No.:

SECTION 2– CHILD and/or GRANDCHILD INFORMATION (Complete this section ***only*** if applying for a life insurance policy for your child and/or grandchild. Section 5 must be completed for a child/grandchild life insurance policy.)

Child/Grandchild #1 (Provide first name, middle initial, last name)		**Child/Grandchild #2** (Provide first name, middle initial, last name)	
Relationship: ☐ Child ☐ Grandchild	☐ Female ☐ Male	Relationship: ☐ Child ☐ Grandchild	☐ Female ☐ Male
Place of Birth: (State)		Place of Birth: (State)	
Date of Birth:	Age:	Date of Birth	Age:
For ages 16 and above, has the person applying for insurance used tobacco in the past 12 months? ☐ Yes ☐ No		For ages 16 and above, has the person applying for insurance used tobacco in the past 12 months? ☐ Yes ☐ No	
Plan of Insurance: Flexible Premium Adjustable Life Insurance (UL) Specified Amount: $ _____ Planned Periodic Premium: $ _____ per week		**Plan of Insurance:** Flexible Premium Adjustable Life Insurance (UL) Specified Amount: $ _____ Planned Periodic Premium: $ _____ per week	
Riders: ☐ Accidental Death Benefit *(Benefit Amount Equal to Initial Specified Amount)* ☐ Waiver of Stipulated Premium Rider		**Riders:** ☐ Accidental Death Benefit *(Benefit Amount Equal to Initial Specified Amount)* ☐ Waiver of Stipulated Premium Rider	
Primary Beneficiary: _____ Relationship: _____		Primary Beneficiary: _____ Relationship: _____	
Contingent Beneficiary: _____ Relationship: _____		Contingent Beneficiary: _____ Relationship: _____	

SECTION 3 – POLICY CHANGE TO EXISTING POLICY COVERAGE

☐ **Increase Specified Amount to $**_____ / ☐ **Increase Planned Periodic Premium to $**_____

Riders:

***Accidental Death Benefit Rider**	**Children's Term Insurance Rider**	**Automatic Benefit Increase Rider**
☐ Add Rider * Coverage amount may not be more than the Specified Amount of Policy.	☐ Add Rider ☐ $5,000 or ☐ $10,000 ***(List dependent children's name in the below section)*	☐Add $1 Wk. Increase for the first: ☐5 Yrs. ☐10 Yrs. ☐Add $2 Wk Increase for the first: ☐5 Yrs.

** **For the Children's Term Rider** -List all unmarried dependent children who are under age 19 and proposed for coverage. (Attach a separate sheet for additional persons not listed.)

Name (First, Middle Initial, Last Name)	Relationship	Date of Birth

SECTION 4 – REPLACEMENT & IN FORCE INSURANCE – REGARDING ALL INDIVIDUALS TO BE INSURED

1. Will any existing life insurance or annuity with this or any other company be replaced, changed, or used as a source of premium payment for the insurance applied for? (If "Yes", list below.) ☐ Yes ☐No

2. Does any individual applying for insurance have any in force life insurance policies or annuity contracts? (If "Yes", list below.) ☐ Yes ☐No

Name of Person	Name of Company	Type of Coverage	Insurance Amount	Accidental Death	Year Issued	To Be Replaced
						☐ Yes ☐No
						☐ Yes ☐No
						☐ Yes ☐No

SECTION 5 – EVIDENCE OF INSURABILITY (Complete as required for all individuals applying for coverage subject to underwriting).

	Employee (Applicant)	**Spouse**	**Child** / **Grandchild** #1	#2
1. Provide height and weight for each proposed insured.	Height _____ft. _____in. Weight _____lbs	Height _____ft. _____in. Weight_____lbs	Height _____ft. _____in. Weight_____lbs	Height _____ft. _____in. Weight_____lbs
2. Has the proposed insured in the past 6 months prior to application been a) seen by a physician for anything other than a cold, flu, or routine examination; b) hospitalized; or c) disabled due to accident or illness?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has the proposed insured missed more than 5 consecutive days of active work due to an illness or injury in the past 6 months prior to application?	☐ Yes ☐ No	☐ Yes ☐ No	N/A	N/A
4. Has the proposed insured ever been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 5 years has proposed insured had heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding HIV antibodies); liver disease; lung disease; memory loss; dementia; mental disorder; nervous system disorder; or other known health impairments not included on this list?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 5 years has the proposed insured received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has the proposed insured taken any prescription medicine in the past 12 months? If "yes", state name of medication, reason for taking, frequency and dosage.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

REMARKS – Provide details to "**yes**" answers for Section 5 Questions 2 – 7 in space provided below. (Attach extra sheet of paper, if necessary.)

Question Number	Name of Person	Details *(Include duration, impairment, diagnosis, treatment, medication, date of occurence, current status, and name, address and phone number of all doctors, hospitals and medical facilities.)*

SECTION 6 – CONDITIONAL AMENDMENTS TO APPLICATION

If coverage cannot be issued as initially applied for, I hereby authorize Conseco Insurance Company to amend the application under the following circumstances:

- Issue a lesser benefit amount. ☐ Yes ☐ No
- Issue coverage on the remaining individuals applying for coverage if any one person's coverage is declined. ☐ Yes ☐ No
- Increase or decrease the premium amount to cover the benefit actually issued. ☐ Yes ☐ No

NOTE: NONE OF THE ABOVE CONDITIONAL AMENDMENTS CREATE ANY ADDITIONAL OBLIGATION BY CONSECO INSURANCE COMPANY TO ISSUE COVERAGE TO ANY INDIVIDUAL PROPOSED FOR COVERAGE.

SECTION 7– DECLARATIONS & AUTHORIZATION

I represent that all statements and answers made in all parts of this application are full, complete and true. It is understood and agreed that:

1. All such statements and answers shall be the basis for and become a part of any life insurance issued as a result of this application.
2. No agent, producer, broker nor examiner has the authority to accept risks, to make or change contracts or to waive any of the Company's rights or requirements.
3. As a condition precedent to coverage taking effect on the Policy Effective Date, all persons to be covered under the policy must be alive and not in a hospital, nursing home or other medical facility, which provides skilled medical care on the Policy Effective Date and the full first premium must be paid. **Deferred Effective Date of Coverage** will apply, if any person to be covered under the policy is in a hospital, nursing home or other medical facility on the Policy Effective Date. The insurance coverage will not become effective until the date the covered person is discharged from the hospital, nursing home or other medical facility and is able to perform his/her normal activities.
4. Acceptance of a policy by the Owner constitute ratification of any changes made by the Company.
5. I authorize my employer to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which my employer cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my employer in writing to cancel the premium deductions.

I understand that Conseco Insurance Company (hereinafter, collectively "Company"), affiliates of the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any: (1) life insurer; (2) reinsurer; (3) insurance support organizations, including MIB (Medical Information Bureau); (4) financial source; (5) employer and other like sources, to give the types of information listed below when this Authorization is presented.

The types of information may include my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS); (10) drug and alcohol treatments; (11) other personal information; (12) government records, such as motor vehicle record and (13) prescription drug records and related information. **A separate HIPAA compliant authorization is needed to authorize release of information from health care providers and related facilities.**

The Company and its reinsurers will use the information in order to determine whether I am insurable pursuant to the Company's underwriting standards. The insurance agent, producer, or broker may also use the information to help update and improve my insurance program.

Those parties authorized above, excluding insurance support organizations, may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply for insurance; (2) reinsurers; (3) the Medical Information Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law.

This Authorization will be valid for 24 months after the date of signing and cannot be revoked. A copy of this Authorization shall be as valid as the original. I understand I have a right to receive a copy of this Authorization. I acknowledge receipt of a copy of the "Notice of Information Practices," which includes pre-notification information relating to investigative consumer reports and the Medical Information Bureau, Inc.

Soliciting Agent Statements:

1. Will there be any replacement, as defined by any regulation of the state in which this application is taken? (If "YES", fulfill all state requirements.)
   ☐ Yes ☐ No
2. I certify that I did not use an illustration in the sale of this life insurance policy. I have informed the applicant/owner that an illustration conforming to the life insurance as issued will be provided no later than at the time of policy delivery.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

Signed at _____ **on** _____

City and State **Month, Day, Year**

Sign Full Legal Name

I certify that I did not receive an Illustration in the sale of this life insurance policy. I understand that an illustration conforming to the life insurance as issued will be provided no later than at the time of policy delivery.

X _____
Signature of Applicant/Owner

X _____
Signature of Witness
(Licensed Agent must witness where required by law)

X _____
Agent Signature

X _____
Print Agent Name

_____
Agent Number (Company Number)

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CNSC-125847795*	*State:*	*Arkansas*
Filing Company:	*Conseco Insurance Company*	*State Tracking Number:*	*40609*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CIC-7025 & CIC-8014A1*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/07/2008

Comments:

The other notices not needed for application/endorsement filing.

Attachment:

READABILITY CERTIFICATION.pdf

Review Status:

Satisfied -Name: Application comparison chart 10/20/2008

Comments:

Attachment:

Changes to Medical Question Chart.pdf

READABILITY CERTIFICATION

Company Name: Conseco Insurance Company

NAIC Number: 233-60682

As an officer of Conseco Insurance Company, I hereby certify that the below captioned forms achieve the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements in your state.

Flesch Score	Form Number	Description
52.1	CIC-8014 A	Life Application Supplement
50.1	CIC-7025	Endorsement

Mariann Dobbs

_____ **10/14/2008**

Mariann Dobbs **DATE**
Assistant Secretary

COMPARISON CHART	
Application CIC-8014A (Previously Approved Questions)	Application CIC-8014A1 *(Revised Questions)*
#1 Provide height and weight for each person applying for insurance coverage.	#1 Provide height and weight for each proposed insured.
#2 In the past 6 months, prior to the application, has the person applying for insurance coverage: a) been seen by a physician for anything other than a cold, flu, or routine examination; b) been hospitalized; or c) been disabled due to accident or illness?	#2 Has the proposed insured in the past 6 months prior to application been a) seen by a physician for anything other than a cold, flu, or routine examination; b) hospitalized; or c) disabled due to accident or illness?
#3 Has the person applying for insurance ever been diagnosed by a physician as having AIDS?	#3 Has the proposed insured ever been diagnosed by a physician as having AIDS?
#4 Answer question if coverage is being applied for on the employee and/or spouse – in the last 6 months, prior to the application, has the person applying for insurance missed more than five consecutive days of work due to accident and/or illness	#4 Has the proposed insured missed more than 5 consecutive days of active work due to an illness or injury in the past 6 months prior to application?
#5 in the past 10 years has the person applying for insurance had heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding HIV antibodies); liver disease; lung disease; memory loss; dementia; mental disorder; nervous system disorder; or other known health impairments not included on this list?	#5 In the past 5 years has the proposed insured had heart disease; chest pains; high blood pressure; stroke; diabetes; cancer; tumor; kidney disease; blood disorder (excluding HIV antibodies); liver disease; lung disease; memory loss; dementia; mental disorder; nervous system disorder; or other known health impairments not included on this list?
#6 In the past 10 years has the person applying for insurance received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use?	#6 In the past 5 years has the person applying for insurance received medical treatment or counseling, or been advised to seek treatment for alcohol or illegal drug use?
#7 Has the person applying for insurance seen a physician in the past 12 months or currently taking any prescription medications? Below provide details to include: reason seen, medication name, dosage and reason for taking.	# 7 Has the person applying for insurance taken any prescription medicine in the past 12 months? If “yes”, state name of medication, reason for taking, frequency and dosage. Provide height and weight for each person applying for insurance coverage.